Pure Joy PEDIATRICS

15405 SW 116th Ave, Suite 116 | King City, OR 97224 | Phone: 503-420-8667 | Fax: 971-512-3246

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Patient's Name: _____ Patient's Date of Birth: ____/____/_____

Parent's Name: _____ Phone number: _____ (optional)

I request and authorize:

Physician: _____

Clinic/Office: _____

Fax #: _____ Phone #: _____

to release healthcare information of the patient named above to:

Pure Joy Pediatrics, LLC
15405 SW 116th Ave, Suite #116
King City, OR 97224
Fax: 971-512-3246
Records@PureJoyPediatrics.com

For the purpose of: ❍ Transfer of care ❍ Personal Use ❍ Legal ❍ School ❍ Job ❍ Other

This request and authorization applies to:

❍ All healthcare information ❍ Other

❍ Healthcare information relating to the following treatment, condition, or dates

Please send the entire medical records (all information) to the above named recipient

I authorize the information listed below to be used, disclosed, or received by placing my ***INITIALS*** next to the information:

_____ STD results/HIV/AIDS
_____ Mental Health information (including provider's notes)
_____ Genetic testing information
_____ *Alcohol and Drug information

*PROHIBITED RE-DISCLOSURE: This information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit you from making any further disclosure of this information without the specific written consent of the person to whom it pertains or as otherwise permitted b 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

This authorization is limited to the following time period: _____

My signature indicates that I authorize the disclosure of the above information and understand the following:

I understand that I may choose not to sign this authorization and that my choice not to sign will not be a basis to affect my ability to obtain treatment or my eligibility for health care benefits.

I understand I can cancel permission to use and disclose my information at any time in writing. The only exception is when action has been taken in reliance on the authorization. Unless revoked earlier, this consent will expire 180 days from the date of signing, or shall remain in effect for the period reasonably needed to complete the request.

I understand this change will not affect information that has already been shared.

I understand that federal and state law protects my health information. However, my information could be shared with agencies or businesses that may not be covered by this law. They could then share my information with others. I understand that they cannot share information regarding HIV/AIDS, mental health treatment, alcohol and drug treatment or genetic testing unless I give them permission by initialing this permission above or as otherwise permitted by law.

Patient Signature (if over age 14): _____ Date Signed: ____/____/_____

Parent/Guardian Signature: _____ Date Signed: ____/____/_____